Royal Berkshire
NHS Foundation Trust

Acute Frailty Pathway
Royal Berkshire Hospital

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Royal Berkshire NHS Foundation Trust

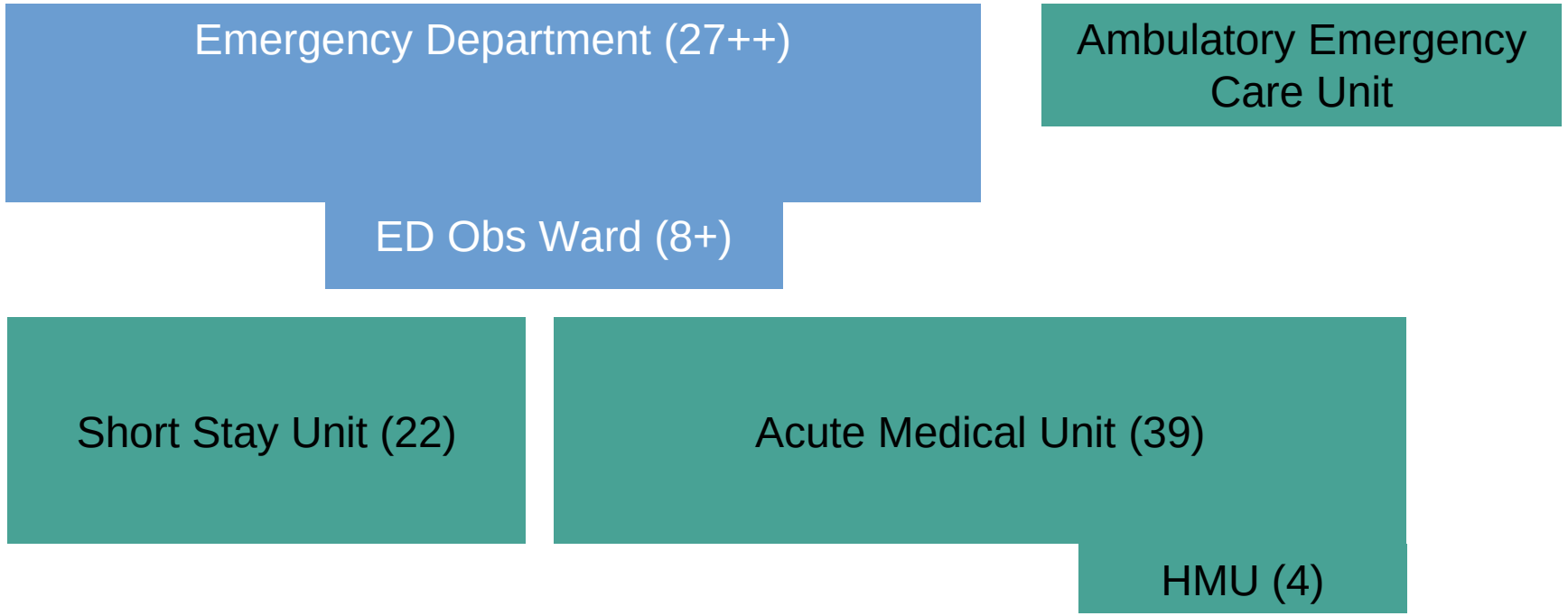
"Working together to provide outstanding care for our community"

- Approx 500,000 patients in Berkshire and South Oxfordshire.
- 5 different Unitary Authorities & at least 6 CCGS
- Average of 1200 patients over the age of 75 attend ED every month.
- 130 Elderly Care beds across 6 wards.
- Approx 30 new elderly care admissions every twenty-four hour period.

Acute Frailty at the Royal Berks

- ❑ Emergency Department
- ❑ New Frailty Service & ED OT Team
- ❑ ECPOD
- ❑ Interface Geriatrics
- ❑ RACOP (& RACU)
- ❑ FFR
- ❑ RRAT
- ❑ Elderly Care wards
- ❑ Hip fracture unit & HFESD

RBH Acute area



Older people in E.D. at RBH

- >300 patients per day
- 60 patients in ED at one time every day
- Only 27 bed spaces
- Priority to critically unwell, trauma, sepsis, stroke, chest pain
- Older patients attending ED increased by 25% in 4 years
    - Conversion rate >80%
- E.D. Obs ward – supposedly low risk patients only
    - Difficult to achieve
    - Admission rate 20%

RBH E.D.

- Clinical champion leading service improvement
  - Increased cognitive assessments
  - Enhanced medication in Parkinson's disease
    - (identification & administration)
- New Frailty Friendly Front Door
  - Frailty screening/identification
  - Frailty Practitioners

The Frailty Friendly Front Door has gone live!

Frailty Practitioners are now in the Emergency Department

Bleep 579

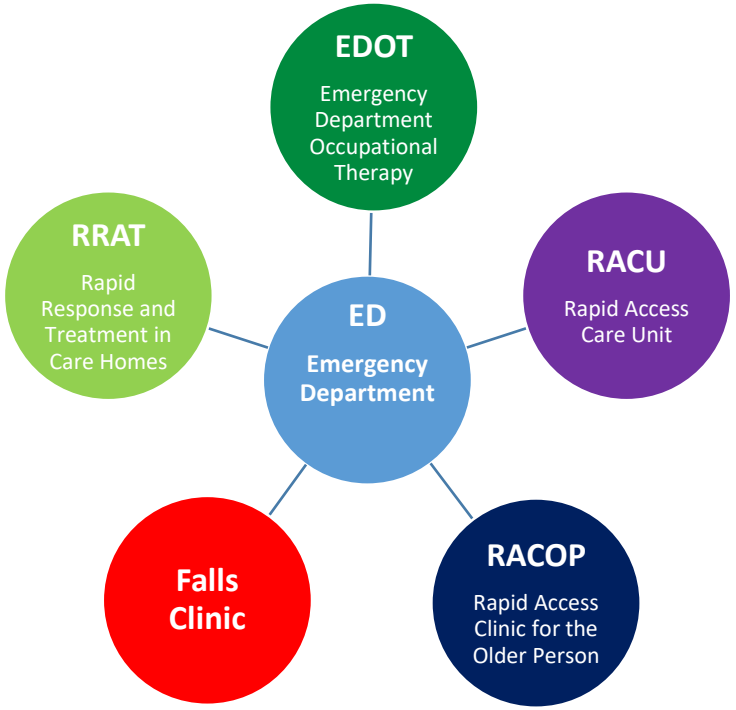
8am – 8pm, 7 days a week

The team will be carrying out parallel assessments alongside the Emergency Department doctors, to expedite prompt discharge home and/or referral to alternative pathways, for patients living with frailty.

THINK FRAILTY ON ARRIVAL

IN ALL over 65s

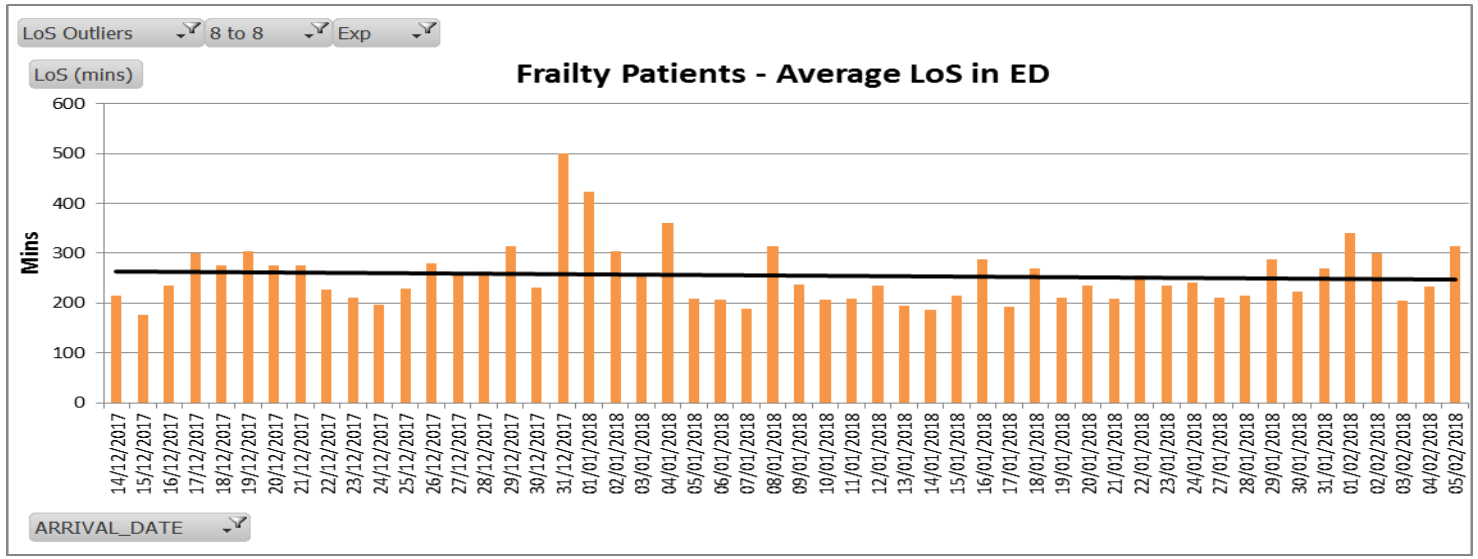
- **F**alls
- **R**educed mobility
- **A**cute/chronic confusion
- **I**s known Parkinson's
- **L**ives in a Care Home



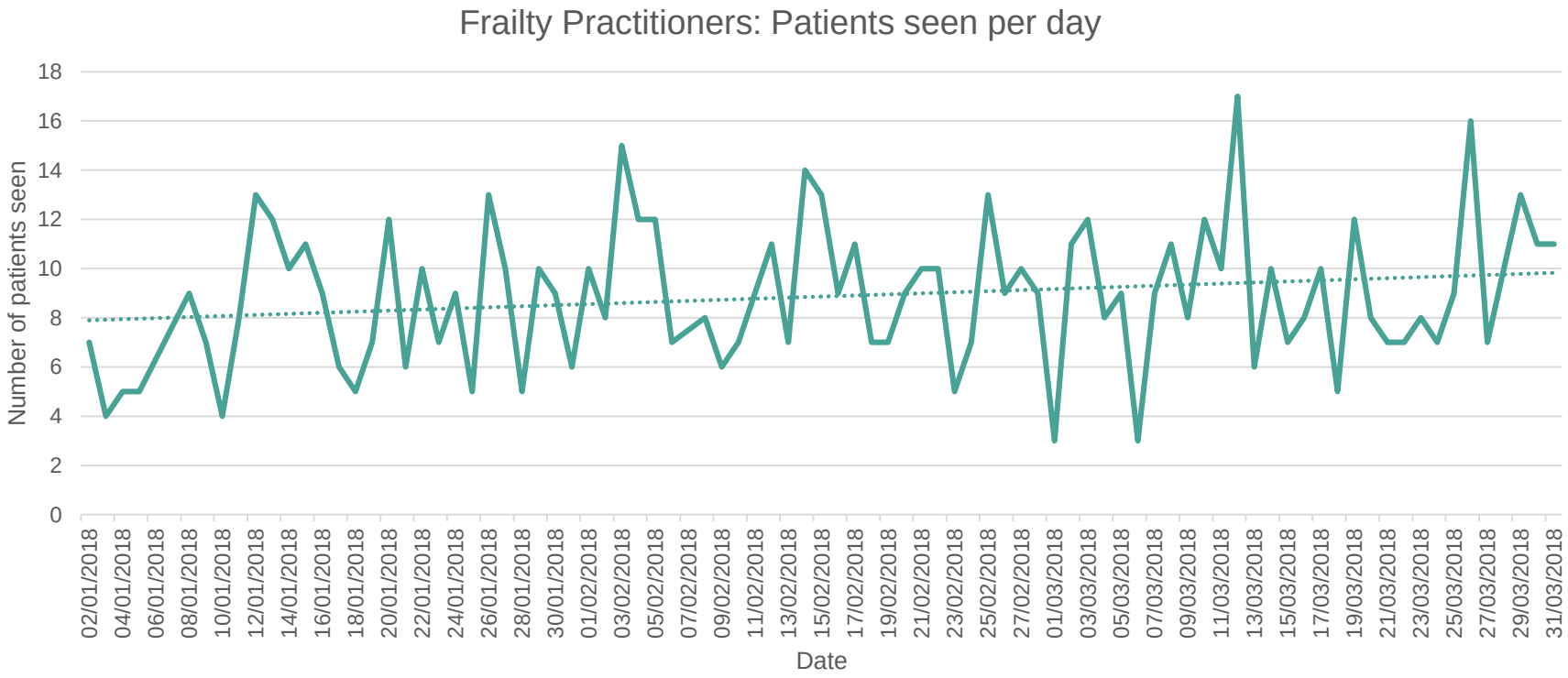
THINK 5 TO GET HOME FIRST

What has been achieved?

ED (USING FRAILTY FLAG from 14th Dec)	BEFORE	AFTER	VARIANCE
	14th Dec to 7th Jan	8th Jan to 8th March	
Attendances (ave day)	22.1	22	-0.1
Re-attendances (ave day - within 72 hours)	5	2.5	-2.6
Re-attendance Rate (within 72 hours)	22.8%	11.2%	-11.6%
Average Length of Stay in ED (mins)	272	237	-35



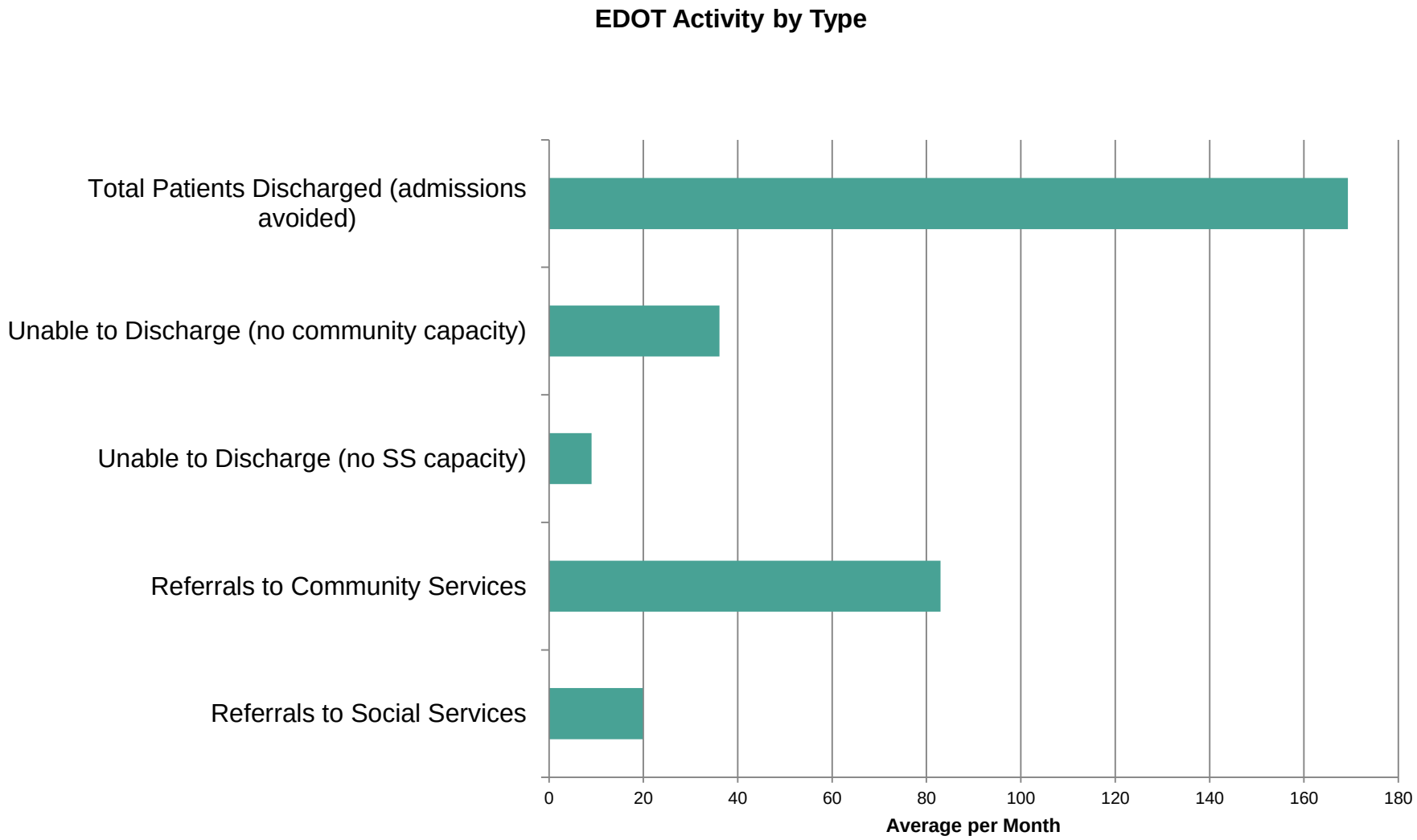
Frailty Practitioner Activity



Emergency Department Occupational Therapy Team (EDOT)

- Occupational Therapy cover 9am – 9pm, 7 days/week
- Physiotherapy cover 8am – 4.30pm, Monday to Friday (AMU/SSU)
- Review 10 – 18 patients daily
- Work closely with Frailty Practitioners
    - Along with ECPOD & Interface teams
- Access to home & bed based intermediate care
- Approx170 admissions per month avoided

ED OT


EDOT Activity by Type
Total Patients Discharged (admissions avoided)
Unable to Discharge (no community capacity)
Unable to Discharge (no SS capacity)
Referrals to Community Services
Referrals to Social Services
0
20
40
60
80
100
120
140
160
180
Average per Month

Acute Medical Unit (AMU)

- 39 bedded admission unit
    - With HMU (4 beds)
- Alongside Short Stay Unit (SSU)
- Integrated unit with Acute Physicians & Geriatricians
- Dedicated therapy team
- Daily MDT board round
- Daily specialty visits
    - Cardio, Resp, Gastro, Oncology, Neuro

Elderly Care Physician Of the Day (ECPOD)

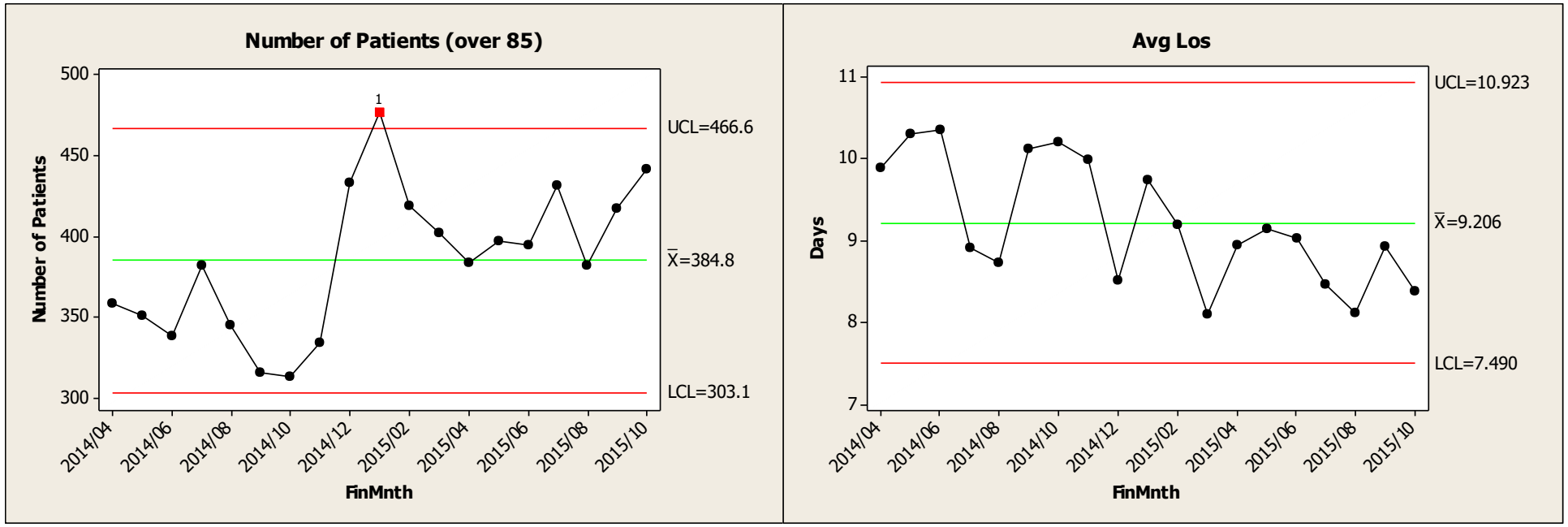
- ❑ 8am – 8pm every day
- ❑ See all new Elderly Care admissions
- ❑ Advice & guidance for ED & GPs
- ❑ Review RACOP patients
- ❑ Provide senior cover to elderly care wards at weekends

– Medical admissions allocated to Elderly Care Physician on basis of need – triaged by admitting juniors

Interface Geriatrics

- ❑ Daily consultant led input to AMU & SSU
- ❑ Support & enhance ECPOD service
- ❑ Liaison with ED, downstream wards, community
- ❑ CGA etc
- ❑ Signpost & liaise with community teams/services/geriatricians

- Introduction of service associated with LOS reduction
- Expansion of service limited by recruitment



Seeing more patients, and they stay less time…

Rapid Access Clinic for the Older Person (RACOP)

- 4 clinics per week (15 patients)
- MDT approach:
  - Registrar led with Consultant review
  - Nursing, physio & OT input
- Telephone/bleep referral introduced
- Transport limits access to clinic

- Weekly dedicated MDT Falls Clinic
- New RACU set up in Community Hospital in Henley

Falls and Frailty Response Service (FFR)

- Joint initiative with South Central Ambulance Service.
- Blue light response service, working Sat/Sun/Mon 7am-7pm.
- OT and Paramedic working together to assess older patients who have fallen at home.
- Pre-hospital assessments and functional/cognitive assessments.
- Equipment/pendant alarms provided. Care packages adjusted.
- Onward referrals to community services, voluntary sector, RACOP, Falls Clinic, GP/OOH.

FFR

- Aim to reduce unnecessary conveyance to A&E and treat older people living with frailty in their own home.
- Between October 2017 and March 2018 attended 169 patients with a non-conveyance of 74% (26% of patients conveyed to hospital).
- Therefore 125 patients being seen, assessed and treated at home
- 44 patients required transport to hospital
    - reasons included sepsis, ? #NOF, fall with long lie, head injury on warfarin

RAPID RESPONSE AND TREATMENT (RRAT) FOR CARE HOMES

- Initial attempt to set up “Hospital at Home”
- Aim to reduce admissions or LOS
- 7 day service: 8 am to 8 pm
- Initial care home inclusion of the 15 highest for calls, conveyance, A&E & admissions
- MDT (with Pharmacy) & Community geriatrician specialist input
- Pilot: Reduced ambulance calls & admissions
- Now all care homes in Berkshire West

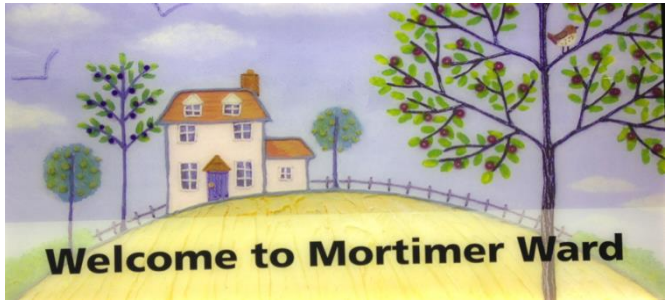
RRAT

- CGA and ACP in the Care Home
- “Admission avoidance” with iv therapy
- Capped rise in 999/A&E/Non-elective admissions
- 984 patients seen by RRAT team

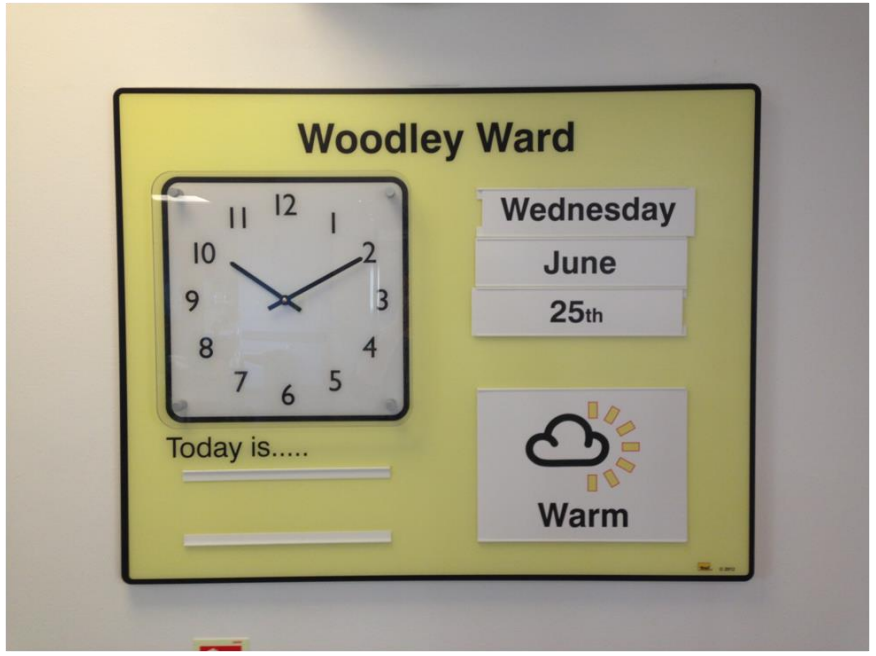
- Meds management is a saving of £100 per patient
  - 37 care homes reviewed
  - Estimated regional saving approaching £400,000

Elderly Care wards

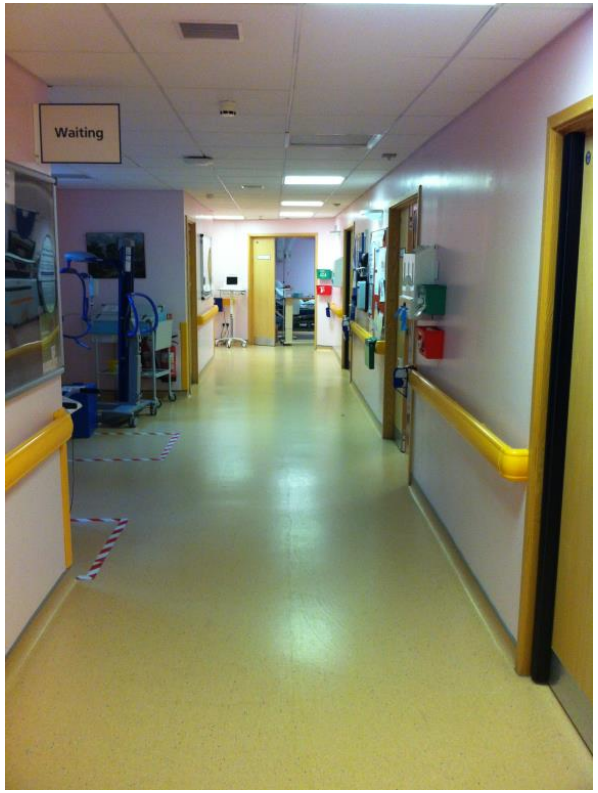
- Dementia friendly wards
- Daily MDT board rounds
- Open Visiting
- Enhanced Recovery programme
- Dedicated Hip Fracture Unit
  - With new Early Supported Discharge



Orientation



Before & After



Day rooms


1940s
1950s
1960s
Reading Chronicle
1970s
Shopping
A Sporting Life

Hip Fracture Unit

- 24 bed unit created following bed remodelling
- Improved pathway in which patients are admitted direct to the unit from ED
- Raised awareness with bed management, ED and throughout the hospital

- Reduction in LoS from 19.4 to 15.2 days
- A successful business case for a new Specialty Doctor for the unit
- Winning the 2016 HSJ Value Award

Hip Fracture Early Supported Discharge

- CEO's Transformation fund 2017
- Targeting DTOCs on Hip Fracture Unit
- Outreach Service to 'Bridge the gap' in patient's homes until community services commence
- First month launch – 20 patients, total of 47 bed days and 80 community care calls saved
- Aiming for 3 day ↓ in NOF# LOS (currently 13.2)
- The future ?Expand the service across clinical areas – include more members of the MDT

Future plans in Reading

- Review of Acute Medical Pathway
- Digital Hospital Programme
- Enhanced Pharmacy support
- Expanding Interface Geriatrics
- Connected Care Portal
- OPAL for medical wards
- Telephone advice – GP/ED

Questions?